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Pediatric Illness

Perry Memorial Hospital

Printed:
11/18/2013 07:59
Time/Date Seen
(If Different):Mode of
Arrival:
☐ EMS
☐ Other

Instructions:

Vital Signs:

Pulse Ox:

Cardiac Monitor:

Circle pertinent positive findings

Stable except:

Normal Hypoxic

Rate: NSR

BP

Not Applicable

Brady Tachy

Backslash pertinent negative findings

Pulse

% on Room Air or O₂ @

Rhythm: Sinus Afib Junctional Ectopy: None PVCs PACs

INDICATORS: * HQI ▲ PQRS

R Rate

Temp

HISTORY:

HX from Patient: Unobtainable due to:

HX from: Patient Family / Caretaker

Altered Mental Status Extremis Unaccompanied

Interpreter Medical Records LMP:

CHIEF COMPLAINT:

This is a 9 month / year old male / female who presents with a complaint of: Fever Ill-Appearance
another states perineum red p-beeing & father, child control fight

ONSET/DURATION

Started 1 Min Hours Days Weeks Ago Still Present Resolved Worse Since:

TIMING

Constant Intermittent Episodes Lasting Sec Min Hours Days Weeks

SEVERITY

Max Temp: F / C Unknown Initially: Mild Moderate Severe Currently: None Mild Moderate Severe

LOCATION

Associated Pain: None Diffuse Discrete @: Radiates to:

CHARACTER

Sharp Dull Aching Throbbing Unable to Describe

AGGRAVATING

Position Movement Feeding

ALLEVIATING

Antipyretics Bronchodilators OTC Meds: Dose / Time: Nothing

ASSOCIATED

Negative Fever Decreased Activity Lethargy Irritability Rash Nothing

SIGNS AND

Nasal Congestion Ear / Mouth / Throat Pain Cough Wheezing Difficulty Breathing

SYMPTOMS

↓ Oral Intake Abdominal Pain Vomiting Diarrhea Dysuria

RELATED HX

Similar Episode / Dx as:

Recent Tick Bite / Exposure

Serious Bacterial Infection

Risk Factors:

(Meningitis / Sepsis / UTI)

Negative Age 3 Mo: Neonate Prematurity Positive Maternal Group B Strep Culture / Peripartum Maternal Antibiotics
Age 3 Mo: Unimmunized Sickle Cell Disease / Immune Deficiency
UTI: Prior UTI Female 2 Years Male 6 Months or Uncircumcised Antibiotics / HSV

REVIEW OF SYSTEMS:

Pertinent Positives

Constitutional	Negative	Fever	Chills	Decreased Activity
Eyes	Negative	Discharge	Redness	
ENT	Negative	Ear / Mouth / Throat Pain		
CV	Negative	Rapid Heart Rate	Cool Extremities	
Respiratory	Negative	Cough	Wheezing	Difficulty Breathing
GI	Negative	Vomiting	Diarrhea	Poor Feeding
GU	Negative	Dysuria	Decreased Urinary Frequency	
MS	Negative	Extremity Disuse	Swelling	
Skin	Negative	Rash	Cyanosis	
Neuro	Negative	Lethargy	Irritability	Seizures
Psych	Negative	Abnormal Interaction w/Parents (specify)		

All other systems reviewed and negative: Yes No

Additional Pertinent History:

PCP / Managing Physician(s):

Referred to ED / Clinic by: PCP / Telephone Referral / Other:

Previous Visit for Same Complaint to ED/Clinic/PCP/In-Patient Within

72 hours / Days Dx / Rx:

Current Antibiotic(s): None

Acetaminophen / Ibuprofen Dose / Time:

Levels 2 - 3: 1 System Level 4: 2 Systems Level 5: 10 Systems / Disclaimer

FAST MEDICAL HISTORY:

Previously Healthy

Birth Weight: Lbs / Kg

PMH / FH / SH: Levels 1 - 3: 0 Level 4: 1 Level 5: PMH plus FH or SH

Birth History	Normal	Abnormal	Prematurity	
Immunizations	UTD	Not UTD	HIB PneumoCV Pertussis Rotavirus Synagis®	
ENT	None	Otitis Media Pharyngitis		
Respiratory	None	Asthma Bronchiolitis / RSV Pneumonia		
GI / GU	None	GERD UTI		
Chronic Illness	None	Seizure Disorder DM I Sickle Cell Disease Cerebral Palsy		
Surgical History	None	Ear Tubes T & A Splenectomy V-P Shunt Indwelling Central Venous Catheter		

* Influenza Vaccine Within Last 12 Months:

Yes No Unknown

FAMILY HISTORY:

Negative

Asthma
Seizures
Other:

SOCIAL HISTORY:

Negative

Exposure to Passive Smoke
Infectious Exposure
Attends: Day Care/School Lives With: Family/Foster Care/Group Hm
Other:01333591
KRAMER MADELINE H
20509 2300 N AVE
DR CERNOVICH
DR778905
F 9M
OHIO
DR NO DOCTOR
11/18/13 B/D 01/20/13
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PHYSICAL EXAMINATION:

EXAM LIMITED DUE TO: Uncooperative Altered Mental Status Extremis Other:

	Normal Findings:	Abnormal Findings:	Complaint-Specific Findings
Appearance	Normal	Ill-Appearing: Mild Mod Severe Pain Distress: Mild Mod Severe Resp. Distress: Mild Mod Severe	Ill Appearance: Yes ☒ No Altered Mental Status: Yes ☒ No
Eyes	Normal	Conjunctiva Inflamed / Discharge	Anterior Fontanelle: Closed Flat Bulging Sunken
ENT	Normal	TM Erythema / Bulging / Immobile Nasal Clear / Purulent Drainage Dry MMs / Lesions Erythema / Exudate / Enlarged Tonsils	Meningeal Signs: Nuchal Rigidity: Yes ☒ No Brodzinski's Sign: Yes ☒ No Kernig's Sign: Yes ☒ No
Neck	Normal	Nuchal Rigidity Tenderness @ Enlarged Nodes @	Retractions: Nasal Flaring Supraclavicular Intercostal Diaphragmatic Grunting Respirations Inadequate Effort
Respiratory	Normal	Airway Obstructed / Stridor Crackles @ Wheezes @ Breath Sounds @ Retractions	Extremity Disuse @ Joint Swelling @ Skin Rash: Petechial Purpuric Macular Papular Vesicular Urticarial Erythema Warmth
Cardiovascular	Normal	Tachycardia Bradycardia Murmur: Grade / VI Systolic Diastolic Distal Pulses: Weak Absent Delayed Capillary Refill	
GI / GU	Normal	Tender @ Mass @ Bowel Sounds Hypo Hyper Hepatomegaly / Splenomegaly	
Musculoskeletal	Normal	Limited @ Edema @ Pale / Diaphoretic Rash (specify): Cyanosis @	
Skin	Normal	Fatigued / Lethargic / Unresponsive Muscle Tone	
Neuro	Normal	Response to Family: Decreased / Consolable / Inconsolable	
Psychiatric	Normal		

DIFFERENTIAL DIAGNOSES / HQI / PQRS:

Consideration of the following conditions may be warranted for the presenting problem; they are not final diagnoses

Acute Otitis Media Neonatal Herpes
Bacteremia Pharyngitis / Stomatitis
Bronchitis / Bronchiolitis Pneumonia
Gastroenteritis Pyelonephritis / UTI
Hypoglycemia URI / Viral Syndrome
Meningitis Rocky Mountain Spotted Fever

Other:

RE-EVALUATION:

Time: _____ Unchanged Improved Worse VSS Pain Scale (0-10)

Time: _____ Unchanged Improved Worse VSS

PHYS. NOTIFICATION/CONSULTS: Chart Copy Available to Add'l Care Providers

Discussed case/management/disposition of patient with:

Name: _____ at _____ a.m. / p.m.

Name: _____ at _____ a.m. / p.m.

Admit/Transition Orders Written by ED Provider: Yes / No

Reviewed with: _____

Admit to: _____ Consult Follow-up: _____

DISPOSITION: DISPOSITION DECISION TIME:

Discharge: Home Parent/Guardian School Foster Care Deceased AMA

Admit: ED Obs InPt Unit: ICU OR Floor Condition: Stable Unstable

Patient Endorsed To/Discussed With: _____ @ _____ a.m. / p.m.

Patient Stabilized Within Hospital's Capabilities/Transferred to: _____

Transfer Form Completed

Disposition Rationale: _____

Discussed with: Patient Family Other: _____

After-Care Instructions Given to & Follow-Up Care Discussed w/Patient At Discharge

ED PHYSICIAN DIAGNOSES:

- 1 Cry theme perineur
- 2 diaper rash / dermatitis mild
- 3

Critical Care Provided: 30-74 min / 75-104 min / _____ min

(Excludes time required for other billable procedures)

SIGNATURE:

I have reviewed available Ancillary / Nursing Staff documentation.

PA / NP / Resident

MD/DO

MD/DO

Teaching Physician - I performed a history & physical examination of the patient and discussed the management with the Resident. I reviewed the Resident's note and agree with the findings and plan of care, except as I have documented _____ (Initials)

DISPOSITION TIME:

8/10

DISPOSITION DATE

(if different than above)

Chart Completed: Yes No

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